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ABSTRACT

This student's manual, designed to enhance the skills of inservice and preservice caregivers and professionals who work with the aging and aged developmentally disabled person, is to be used by participants in a program of 10 training sessions entitled "The Aging and Aged Developmentally Disabled." This workbook provides student materials needed to complete the training sessions which are described more fully in the instructor's volume. For each training session in this student's manual, there is an outline of the session format followed by all the materials and forms needed by the participant. Topics covered in the workbook and in the training sessions include: (1) facts about developmental disabilities; (2) facts about the aging process; (3) basic needs of individuals; (4) environmental impacts on human fulfillment; (5) positive and negative effects of labeling persons; (6) the role of the caregiver; and (7) innovative use of community resources. (NRB)

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WORKING WITH AGING AND AGED DEVELOPMENTALLY DISABLED PERSONS

TRAINING MATERIALS FOR CAREGIVERS

BY

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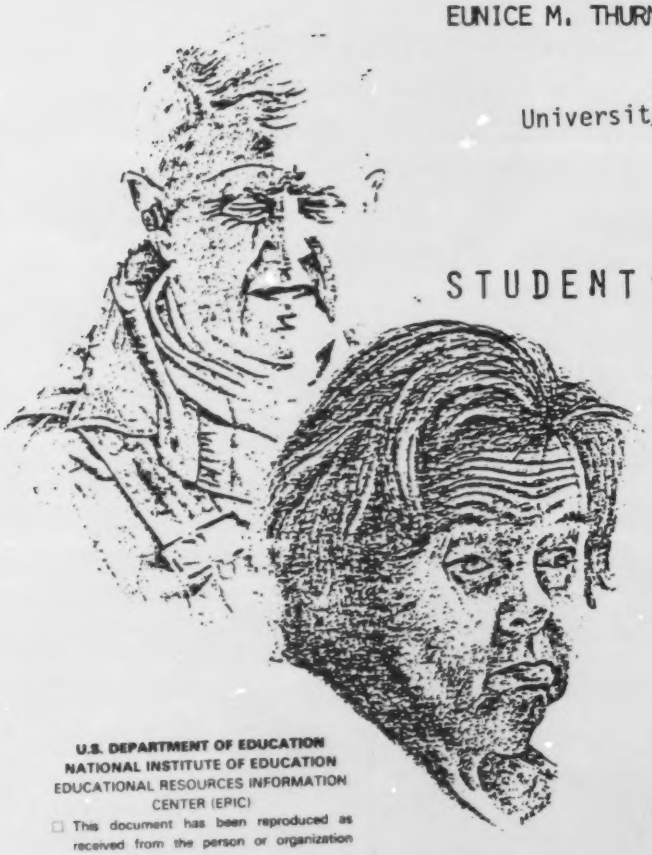
STUDENT'S MANUAL, VOL. II



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SESSION I

AGING AND THE INDIVIDUAL

1. GREETING

2. TRAINING OVERVIEW:
   - Goals for Training
   - Outline and Process of Session
   - "Get the Most From Your Small Group Experience"

3. "THINGS WE TAKE FOR GRANTED" - Videotape

SUGGESTED COFFEE BREAK

4. FEELINGS ABOUT "YOUR DISABILITY"

5. IMPACT OF AGING
   - Small Group: Questions focusing on sensory change and adaptations
   - Large Group: Share-out

INTRODUCTION

Welcome to the training sessions entitled, "The Aging and Aged Developmentally Disabled".

During the next ten sessions we will be working together to achieve the following goals:

1. To gain understanding of factors that contribute to both developmental disabilities and the aging process.
2. To increase awareness of the individual needs of each client.
3. To develop those skills that ensure humanistic treatment of an individual.
4. To learn to use community resources.
5. To improve communication skills with clients, peers and supervisors.

In order to achieve these goals, many methods will be used to facilitate learning including the use of a student workbook. You are asked to bring this workbook to every session; at the end of the training you will have compiled your own references.

The sessions will cover the following topics:

FACTS ABOUT DEVELOPMENTAL DISABILITIES

FACTS ABOUT THE AGING PROCESS

BASIC NEEDS OF EVERY INDIVIDUAL

IMPACT OF ENVIRONMENT UPON HUMAN FULFILLMENT

POSITIVE AND NEGATIVE EFFECTS OF "LABELING"

ROLE OF THE CAREGIVER

INNOVATIVE USE OF COMMUNITY RESOURCES

1. Say I . . . . . .

Talk from your own experience.

Don't psychologize about what other people do or don't do, feel or don't feel. Don't sociologize about society, most men or most women. Don't play "ain't it awful."

Rather, focus on your own feelings, thoughts, concerns, questions, awarenesses, fantasies, reveries and past experiences.

2. Don't attempt to run your trip on other group members.

Listen to what others have to say and respond to show they have been heard, particularly if someone puts out something heavy. Don't ignore, pass over, or go on to something else.

We can learn from the reports of others, particularly if we are open, accepting (you don't have to agree) and understanding. And, as we tell our stories to others, we may learn something new about ourselves.

3. Get into your feelings.

It is often hard to know how we feel about something, particularly if the feeling doesn't measure up to our expectations of ourselves. However, your feelings are you and they're real. Talk about them. You can choose not to act on the feelings, but you can't help the feeling when it happens. By talking about them, the feelings become accessible to you and you can work on changing them if you so choose. If you deny, or avoid, or control, they may influence your behavior in ways that you are unaware of or don't want.

4. Take charge of getting what you want from the group.

Don't criticize or attack the group if what you want isn't happening. Make it happen by sharing your feelings, doing and talking about what you want to explore. Ask questions, self disclose and do some modeling. Take risks. Without risk, nothing happens. Anything worth learning or having is worth taking a risk.

5. Trust in the process.

When a group of people meet regularly to share feelings, experiences and concerns--aspects of their life stories--and are gentle and supportive with each other, significant learning can take place. It requires regular attendance, participation and an agreement to treat what is said in the group with strict confidence.

In a group that "works" or "clicks", closeness and involvement develop and there is a sense of excitement and adventure. Make your group "work" for you.

Matthew Trippe, Ph.D.
Human Fulfillment Project
Institute for the Study of Mental
Retardation and Related Disabilities
May, 1978

"THINGS WE TAKE FOR GRANTED"
Presentation of a video tape
Producer/Director: Jeff Warner
Writer/Narrator: Jane Barr

Abstract:

Developmentally disabled people grow old just as we all do. Information about the normal aging process can help caregivers better understand their elderly disabled clients. In this videotape two young staff members in a group home learn about the disabilities that accompany aging and the loss of "things we take for granted." They are temporarily given blurred vision, a hearing loss, and crippling arthritis. Afterwards, they discuss how their retarded clients might feel about similar handicaps and their own feelings about growing old. We see an older client being spoon fed at a table of younger clients who are feeding themselves and then five different retarded clients try to tell what growing old means to them: death, loss of parents, decisions about placement, and increasing dependence on and patronization by care providers. Finally, a young staff member expresses her determination to help older clients achieve their potential for continuing growth and development.

After viewing this videotape you should be able to:

1. Name several changes caused by the aging process which all of us are likely to experience, whether or not we have a developmental disability like retardation.

2. Discuss why caregivers may need help in becoming more aware of the aging process. Is fear of aging and death a factor?

3. Describe how developmentally disabled people interpret the impact of aging on their own lives.

4. Explain the special needs of elderly, developmentally disabled people when they try to:

   a. make decisions

   b. advocate for themselves

   c. overcome patronization and infantalization

   d. understand the issues involved in facing the final stage of life

Discussion Questions:

1. Betty is in her 50's. She doesn't like the workshop program which she is required to attend. Many women in their 50's don't have to leave their homes to work. Why does Betty?

2. Aged developmentally disabled people who have been in insitutions for most of their lives often behave in childish ways. What conditions in the institutions taught them to behave that way? Which of these conditions are similar to those in group homes? Which are different?

3. "Foot trouble" is a common health problem in old age. If a group home resident refuses to take part in activities which she previously enjoyed, it might be because her feet hurt. How would staff members know that she was not just being obstinate? What other physical changes could be mistaken for behavior problems?

4. Have you faced situations with older clients in which it is hard to help without making them too dependent on you? Can you think of alternative approaches?

5. Have you seen someone's needs or feelings discounted or ignored because he or she was old and developmentally disabled? How can such stereotyping be prevented?

Suggested Readings

Nouwen, H.J.M & Gaffney, W.J. Aging: The Fulfillment of Life. Garden City, NY: Images Books, 1976.

Cameron, M. Views of Aging. Ann Arbor, MI: Institute of Gerontology, 1976.

Ernst, M. & Shore, H. Sensitizing People to the Process of Aging: The In-Service Educator's Guide. Denton, TX: Center for Studies in Aging, North Texas State University, 1975.

HOW DOES IT FEEL TO HAVE A DISABILITY?

This exercise is an opportunity to learn how the activities of daily life are affected by a disability. List the feelings you experienced as a result of the simulation. Consider how your life would be different if you had been disabled since age 5. Use the space below, or on the back of the page, to make notes about the experiences other participants described.

IMPACT OF AGING

Your vision, hearing, appearance, bones and joints change with age. These changes often bring problems for the older person.

1. In what ways will the older individual compensate (make up) for this? Especially consider the areas listed on the newsprint. Also, keep in mind older people you know, and how they adjusted to the change.

2. How can others help the older person compensate?

3. Be sure you are prepared to present your findings to the group.

NOTES:

THE PROCESSES OF AGING

"Grow old along with me!
The best is yet to be,
The last of life for which the first was made:
Our times are in his hand
Who saith, "A whole I planned,
Youth shows but half; trust God:
See all, nor be afraid."

Robert Browning, "Rabbi Ben Ezra"

Understanding the processes of aging goes beyond knowing about the changes that will occur. It is being aware that these changes will happen to you too. Aging and ultimately dying is a very personal process. And it is only through understanding our own aging that we will be able to understand the aging of older developmentally disabled persons.

Aging has a number of characteristics:

1. Happens to everyone, everywhere (universal)
2. Occurs over the years (gradual)
3. Takes place within the environment; is not caused by the environment.
4. Increases the chance of accident and disease (vulnerability)

The last factor increases our physical limitations through these normal processes of aging. What are these limitations?

1.

2.

3.

Changes are especially significant in the following areas:

Vision, Hearing, Touch, Bones & Joints, Appearance.

	WHAT HAPPENS	COPING AND ADJUSTING
VISION	*Glare becomes a problem; more light needed to see; eyes focus more slowly; less clearness (acuity); colors fade; cannot judge distances.*	*Sidelighting; using rugs, shades, lower reflective polish; use many lights, not one bright light. Take more time to focus and make letters large. Use color contrast; use red and yellow for directions, because blues and greens fade; steps should be clearly marked and color coded.*
TOUCH	*Skin is no longer as sensitive to pain, pressure and heat.*	*Stove must be marked clearly for being on and off. (If a person touches the stove, the hand often cannot be pulled away fast enough to prevent a serious burn.) Electric blanket is often not recommended. Temperature of tub water must be carefully checked.*
HEARING	*Presbycusis: Gradual loss of high-pitched and then low-pitched sounds. Background noise interferes. Ear-ringing.*	*Face the person - don't cover your mouth. Speak distinctly. Don't shout (it changes the voice tone). Lower the pitch of your voice. Get the person's attention before speaking. Turn off the radio or T.V. when you want the person's attention. Don't talk while a person is seated near an air-conditioner, etc.*
APPEARANCE	*Skin becomes wrinkled, loses elasticity and becomes dry; hair becomes gray and white because of pigment loss; skin is thinner and therefore more fragile and more susceptible to infection. Brown spots; hair in unwanted places; teeth may drop out; nails lose their luster, grow more slowly, crack because of brittleness. Problems of maintaining cleanliness.*	*Important to help person with his/her self-concept. Important to still be a beautiful person although appearance is changing.*
BONES & JOINTS	*Bones become more porous and lose flexibility and therefore are brittle. Spinal discs compress, making backbone shorter and bowing the back. Ligaments in joins lose elasticity and resilience. Calcium deposits cause arthritis, fractures, bunions, etc.*	*Must be more careful about mobility; stairs must be well marked; ice removed from steps, etc.*

SESSION II

SHARING COMMON NEEDS

1. TRUE - FALSE QUIZ

   - Lecturette/Discussion on the Concepts and issues of the AADD

2. IDENTIFYING COMMON NEEDS

   - Solo/Dyad Exercise: What do all people need when they age?

   - Large Group: "The Seven Basic Needs."

3. "HEY, LOOK AT ME" - Videotape

4. DISCUSSION OF BASIC NEEDS

   - Small Group: Consider the needs of the three AADD persons in the videotape Henry, Robert, Arlene.

WHAT DO YOU KNOW ABOUT THE AGING/AGED DEVELOPMENTALLY DISABLED (AA/DD) POPULATION

1.	About 90% of the AADD population who could use community services don't receive these services.	T	F
2.	The AADD people in nursing homes usually have their needs met there.	T	F
3.	Many people believe that the greatest obstacle to service delivery for the AADD is lack of money.	T	F
4.	The AADD are in double jeopardy because they are old and disabled.	T	F
5.	Many adult education programs exist in the community for the AADD.	T	F
6.	A lot of literature has been written on the needs of the AADD person.	T	F
7.	Community services for the DD increase as they get older because their needs increase.	T	F
8.	Since most AADD people have been institutionalized, more is known about their needs than the needs of normal aging persons.	T	F
9.	Because the AADD person's needs are very similar, it is easier to meet these needs.	T	F
10.	Older people have fewer needs than younger people.	T	F
11.	Memory loss is always a problem for older people.	T	F
12.	All people when they get old become senile to some extent.	T	F
13.	Older persons who are ill need more than medical attention from health practitioners.	T	F
14.	Older people are more vulnerable to diseases and accidents.	T	F
15.	The process of aging starts at birth.	T	F
16.	Different parts of the body age at different rates.	T	F
17.	At the most, 50% of the mentally retarded can become independent socially and economically.	T	F
18.	It is a fact that developmentally disabled people die sooner than the normal population because they age faster.	T	F
19.	Most people develop a greater interest in spiritual concerns as they grow older.	T	F

20. Many elderly persons live in urban areas. T F

21. The majority of all the aged no longer have sexual activity or desires. T F

22. Eight out of ten older Americans have one or more chronic diseases. T F

23. Visual and hearing problems are common among the elderly. T F

24. Unlike the normal aging population, the AADD are very much alike. T F

25. Approximately half of all the elderly have lost all their teeth. T F

26. All mentally retarded persons need some degree of supervision as long as they live. T F

27. Both AADD and normal aging people have low status in our society. T F

28. Transportation is more of a problem for the normal aging person than it is for the AADD. T F

INFORMATION ABOUT AGING

What is gerontology?

The study of the aging process.

Who are the aged?

In our society, persons sixty-five years and older are considered aged. It should be remembered that this is the arbitrary retirement age in our society. It doesn't refer to actual changes in a person.

What is aging?

Aging varies. It involves biological, sociological, and psychological changes and proceeds at different rates in different people.

Are all old people alike?

We expect people to act in certain ways because they are at a certain chronological age. However, older people are as unique as any other age group and all have individual feelings, abilities, and needs.

What is biological aging?

As a person gets older, his body becomes less able to adapt to the environment and is affected more by stress and crisis. However, many individuals learn to compensate for many of these changes and still are quite able.

What are some psychological changes?

As they get older, people usually become more cautious and thorough when learning new skills. This does not mean they can't learn. Often habits and routines become more important. Feelings of loneliness may increase because the aged person doesn't have enough self-fulfilling activities to do.

What is sociological aging?

In our society a person is viewed as aged if she is older than sixty-five years of age. Different religious, cultural, and ethnic groups also view the aging and aged in different ways. This can affect the actions of the person.

What is senility?

Senility is mental confusion and can be caused by strokes, alcoholism, infection, or malnutrition. Often the behavior depends on the older person's social situation. Many times the conditions can be successfully treated.

What is chronic disease?

An illness that goes on for a long time and usually does not result in a severe or acute situation.

How many older people are there in the U.S.?

There are about 23,000,000 Americans sixty-five years and older. In 1980 the total US population tripled from 1900. At the same time those sixty-five and older will have increased eight times. At age sixty-five, the average life expectancy is fifteen more years. At seventy-five you can expect to live another ten years.

What is the untrue myth about old age?

The picture of the older person as sick, fragile, disabled, and sexless is the most inaccurate stereotype.

What are the problems of the aged and aging developmentally disabled?

There are problems that are associated with both aging and developmental disabilities. It is important to understand how both of these areas have impact on the aging DD person. As the person ages, the chances of multiple handicaps increase. Attention must be paid to the individual needs of each person.

But at the same time we cannot forget that each person is a whole human being who has strengths and the power to grow and learn. We must help the aging and aged adjust to their handicaps so they can fully appreciate and celebrate life.

"HEY, LOOK AT ME!"
Presentation of a videotape
Producer/Director: Robin Dudley
Writer/Narrator: Martha Ufford Dickerson

Abstract:

Patronization and infantilization are caused by perceiving clients as faceless members of an unattractive segment of society. This program presents the case for individualized treatment plans for such clients. Three elderly retarded people are introduced and followed through their daily activities and routines. The contrasts between their lives help the viewer understand the need to perceive clients as unique persons. The similarities betweeen their lives, however, help the viewer to see that they share with all people certain basic needs: income maintenance, health maintenance, living arrangements, educational and vocational choice, interpersonal relationships, and crisis management.

After viewing this tape, you should be able to:

1. Identify and discuss several basic needs common to everyone in society.

2. Discuss the client's right to be perceived as a unique person with needs common to all of us.

3. Discuss some of the impediments and barriers to the delivery of equitable service to clients who are aged and developmentally disabled.

4. Discuss the role of the family system and the professional network in maintaining, modifying, and removing the impediments and barriers identified above.

5. Discuss the importance of "living arrangements" as they affect an individual's life.

Discussion Questions:

1. What do you know about the various types of residences for elderly developmentally disabled individuals in your state?

2. To what extent do elderly developmentally disabled clients in your state become involved in making critical decisions about their life plans?

3. What do you know about the role of guardians? Case managers?

4. Are you aware of any advocates in your community who are trying to assist aged developmentally disabled clients in planning their lives and widening their experience?

5. To what extent are services for the so-called "well aged" equally available to the aged, developmentally disabled individual?

Suggested Readings:

Dickerson, M. Social Work Practice with the Mentally Retarded. New York: The Free Press, 1980.

Dickerson, M., Hamilton, J., Huber, R. & Segal, R. The Aged Mentally Retarded, The Invisible Client: A Challenge to the Community." In D.P. Sweeney and T.Y.Wilson (Eds.), Double Jeopardy: The Plight of Aging and Aged Developmentally Disabled Persons in Mid-America. Ann Arbor: The University of Michigan-ISMRRD, 1979.

Kobrynski, B. The Mentally Impaired Elderly: Whose Responsibilty? The Gerontologist, 1975, 15, 407-411.

Schulman, E.D. Focus on the Retarded Adult: Programs and Services. St. Louis, MO: C.V. Mosby, 1980.

Wolfensberger, W. The Principle of Normalization in Human Services. Toronto: National Institute of Mental Retardation, 1972.

SEVEN BASIC NEEDS

The following exercise will help you recognize how the basic needs of an individual must be addressed in a differential manner.

	HENRY
1. Income Options	
2. Home Options	
3. Health Maintenance	
4. Vocational/ Educational Opportunities	
5. Recreation/Leisure-Time/Religion	
6. Interpersonal Relationships	
7. Assistance with Crisis	

Seven Basic Needs (continued)

ROBERT	
1. Income Options	
2. Home Options	
3. Health Maintenance	
4. Vocational/ Educational Opportunities	
5. Recreation/Leisure-Time/Religion	
6. Interpersonal Relationships	
7. Assistance with Crisis	

Seven Basic Needs (continued)

	ARLENE
1. Income Options	
2. Home Options	
3. Health Maintenance	
4. Vocational/ Educational Opportunities	
5. Recreation/Leisure-Time/Religion	
6. Interpersonal Relationships	
7. Assistance with Crisis	

SESSION III

PROBLEMS AND POTENTIALITIES OF THE AADD

1. "BOARD AND CARE" - Videotape

2. FACTS ABOUT MENTAL RETARDATION
   - Lecturette/Discussion using worksheets

3. SITUATION MANAGEMENT
   - Small Group: Problem solving
   - Large Group: Share-out

FACTS ABOUT MENTAL RETARDATION

I. Historical Perspective

"Down through the centuries, there have been members of every population who were unable to adapt fully to the demands of the large society because of limited intelligence. As the civilization became more highly industrial and complex, the individual with limited intelligence became more conspicuous because of his deficiencies, and the community in which he lived assumed greater responsibility for the care and maintenance of the person we now call mentally retarded." [1]

As early as the fourteenth century, some individuals began to recognize the difference between mental illness and mental retardation. This was reflected in an action taken by King Edward II of England, who provided a guide to protect the rights and properties of those individuals who were permanently handicapped. Thus the practice of protection and training for the mentally retarded individual was initiated, which is different from the practice of protection and treatment for the individual who is temporarily handicapped because of mental illness.

II. Increasing Awareness in 1980

"Educational philosophies regarding mentally retarded children have shifted throughout the twentieth century. In the early part of the century, the mentally retarded child was removed from the regular classroom to relieve the teacher and other students of the stress caused by his presence. Subsequently, educators adopted the notion that mentally retarded students would be safer and happier in a classroom that minimized competition. Attempts were frequently made to teach them a simplified version of traditional academic subjects. Today, these attempts have been replaced by the philosophy that encourages individual educational planning to help the person with mental retardation to achieve realistic goals." [2]

Mainstreaming, normalization, and deinstitutionalization became guides for the community as meaningful plans were designed and implemented with and on behalf of mentally retarded citizens.

Mainstreaming assumes that all children will be accepted into the school system because they are people.

Normalization assumes that each mentally retarded individual, regardless of age, will have access to a life style and pattern of living as close as possible to the life style other citizens enjoy in his community.

[1]Dickerson, Martha U., Social Work Practice for the Mentally Retarded. New York: The Free Press, 1981.

[2]Ibid.

Deinstitutionalization is a process that has served to return thousands of individuals to the community from the institutions to be rehabilitated, supported and maintained in more "normalized" situations.

III. Definition

Mental Retardation refers to sub-average intellectual functioning, which originated during the developmental period and is associated with impairment in adaptive behavior.

IV. Causes

In three out of four persons with retardation the causes are not clearly known. Retardation may be introduced during the pre-natal, peri-natal or post-natal stages.

A. Organic - Brain damage due to many causes such as:

1.

a.

2.

a.

b.

c.

d.

3.

a.

b.

c.

4.

a.

b.

c.

d.

5.

a.

b.

6.

a.

b.

B. Non-Organic - Social or psychological damage can be caused by social-cultural factors:

1.

a.

b.

2.

a.

b.

c.

3.

a.

4.

a.

b.

c.

5.

a.

b.

c.

d.

e.

f.

6.

a.

NOTE: A negative relationship is evident in the high incidence of mental retardation in children born into racial/minority and/or low income groups.

V. Incidence and Prevalence

A. Mental retardation is the (most/least) widespread of childhood disorders.

B. It is estimated that _____ individuals in the United States have been diagnosed as mentally retarded and are part of our population today. They and their families present more than _____ persons.

C. A child with retardation is born every _____.

D. The number of mentally retarded is (increasing/decreasing).

VI. Identification

A. The mentally retarded are identified by:

1.

2.

3.

B. The person with mental retardation may have additional handicaps.

1.

2.

3.

4.

5.

6.

VII. Classification

A. _____ (usually called _____)

1.

2.

3.

4.

B. _____ (usually called _____)

1.

2.

3.

4.

C.

1.

2.

3.

4.

D.

1.

2.

3.

4.

VIII. Implications

The trend in the twentieth century to sustain mentally retarded individuals in the community has implications for every social- educational-recreational service system. Even as the child who has mental retardation will participate in regular school programs, the young adult with retardation will become a contributor to the work force. It follows then, that the elderly person who has retardation will receive service along with his age peers from the many agencies designed to meet the needs of senior citizens.

INFORMATION ABOUT DEVELOPMENTAL DISABILITIES

I. Developmental Disabilities

What is a developmental disability?

A developmental disability is a condition that started before age eighteen, will continue indefinitely, and keeps the person from functioning normally in society. Some conditions that are considered to be developmental disabilities are: mental retardation, cerebral palsy, epilepsy, and autism.

How many people have developmental disabilities?

10,000,000 people in the U.S. have developmental disabilities; that is about one out of fifty people.

Can these people adjust to their disabilities?

Some people can live independently with their condition and others are dependent on others for care all of their lives. Developmentally disabled persons are the same as normal persons in that each has unique strengths, problems, and needs.

How can the developmentally disabled have their needs met?

In 1975 Public Law 94-103 was established. It is the Developmentally Disabled Bill of Rights Act and states that all DD persons have the right to treatment services that fit their needs. Agencies serving the DD are supposed to provide comprehensive services that meet individual needs.

II. Some Types of Disabilities Aging Developmentally Disabled People Might Have

What is mental retardation?

Mental retardation is a condition that results in lower than average intelligence. Approximately six and a half million people in the U.S. have been diagnosed as mentally retarded. With training, some mentally retarded people can hold down jobs and live independently. Others need to be cared for throughout their lives.

In three out of four cases, the causes of mental retardation are not known. Some factors that cause mental retardation are genetic disorders, metabolic disorders, social, or psychological damage during the developmental period.

What is cerebral palsy?

Cerebral palsy is a result of non-progressive brain damage in the young child. It results in abnormal movement patterns and muscle tone. Approximately 750,000 people in the U.S. have cerebral palsy. Cerebral palsy can happen before, during, or after birth, and can be caused by infection, birth injury, or disease.

The cerebral palsied person may also have hearing, vision, speech, or perception problems, seizure disorders, and mental retardation. Cerebral palsy is classified according to the parts of the body it affects and to the kind of abnormal muscle tone it results in.

What is epilepsy?

Epilepsy is one of a number of disorders of the nervous system which is centered in the brain. One out of fifty persons has epilepsy. Epilepsy can be caused by brain injury in the developing child, lack of oxygen, chemical imbalance, tumors, and poisons. A person with epilepsy may also have the condition of mental retardation or cerebral palsy.

The epileptic seizure may include convulsions, loss of consciousness, movements of the body, mental confusion, or loss of bladder/bowel control. In 80-85% of the cases, epilepsy can be controlled by using drugs.

III. Other Conditions Associated with Developmental Disabilities

There are some conditions that are not considered developmental disabilities but are often associated with them. These conditions can cause the developmentally disabled person to be more dependent on others.

Blindness

Legal blindness can range from a complete loss of sight to partial vision. A person is said to be legally blind if she can read no more in twenty feet than a normal person could read at two hundred feet. The term is used only if the vision is worse than 20/200 in the best eye after correction is used.

Vision impairments can be caused by disease, congenital problems, or injury. Some vision problems are stable while others get progressively worse over time.

Hearing Impairment and Deafness

If a person has more than a fifteen decibel loss, he is considered to be hearing impaired. If the loss is 85 decibals or more, they are considered to be deaf. Some hearing losses are temporary if they are caused by an infection or by a lot of wax in the ear. Other types of hearing impairments are usually permanent and some will get worse over time.

Hearing impairments can come from congenital problems, infections, birth injury, loud noises, or by a reaction to certain drugs.

Some persons can be helped with a hearing aid but it does not solve all problems. Sometimes a person can hear sounds with a hearing aid but they are so distorted that the person can't understand words.

Speech Problems

There is often a relationship between speech problems and hearing impediments, brain damage, physical defects, motor problems, or mental retardation. Poor speech does not always mean the person has trouble thinking. Sometimes therapy can help the person improve their speech. Other times it may be necessary to encourage non-verbal communication.

Orthopedic Handicaps

Orthopedic handicaps are bone and muscle problems that physically limit a persons's ability to get around the environment. Disease causes about 50% of orthopedic problems while 33% are from birth defects and 17% are from accidents. There are ways to devise orthopedic aids to help the person do as much as he can for himself. Buildings are now being adapted to barrier-free design so that the physically handicapped can get around more easily.

Situation #1

Joy, a new caregiver, wants to do a good job. She is trying to get to know two older clients in the group home. She appears to be accepted by Gayle, but Ruth will have nothing to do with her. She knows that accepting people as individuals is important in a relationship. She is depressed about Ruth's reaction and perceives it as a reflection of her inability to relate to older developmentally disabled clients.

Situation #2

Laverne, an older client, along with three other clients was going to a shopping center. Because Laverne complained, it was suggested that she stay home. Laverne decided to go, anyway. While on the trip, she complained and wanted to go home. The other clients were quite happy at the shopping center and did not want to leave. Finally, Laverne stopped and said: "If you're not leaving, I am!" She turned away. The caregiver, Nancy, thought for a minute, then she...

Situation #3

Cindy, a caregiver, has been unsuccessful in involving clients in a group she has formed for the older developmentally disabled clients in a nursing home. One client, Louise, is not interested in coming. Although Louise is unable to talk or walk, she uses body language and facial expressions to express likes and dislikes. Thomas, another client, went off to his room when told about the group, but not before Cindy had expressed her disappointment to him. Cindy was aware of Louise's feelings because Louise kept shaking her head and frowning. Cindy wheeled her into the room where the group met. Later, Cindy said "I am sure Louise will enjoy the group experience, so I'll wheel her into the group every week. I think she will get over her negative feelings about the group soon. I will keep talking to Thomas and hope he'll decide to come."

Situation #4

Doris, a resident of a group home, has attended the Lakeview Senior Center for six months. Her friend, Sara, also attends, and they both enjoy serving coffee to other seniors who are involved in Bingo and cards. Since neither of them appears interested in other types of participation, most senior center staff people feel this is a perfectly appropriate way for them to be involved. However, some of the seniors, who have become friends of Doris and Sara, feel these women are being "exploited."

SESSION IV

CLASSIFICATION OF "DIFFERENCE"

1. "LABELS, LABELS, LABELS"

   - Discussion focused on feelings about labeled people

2. CLASSIFICATION - USE or ABUSE

   - Lecturette/Discussion on the Impact of Labeling and Classification

3. SITUATION MANAGEMENT

   - Small Group: Problem solving
   - Large Group: Share-out

"LABELING - GOOD or BAD?"

List Positive and Negative Terms
used to describe the following groups

OLD PEOPLE	DEVELOPMENTALLY DISABLED PEOPLE

BOY, DO WE HAVE A WEIRD ONE FOR YOU THIS TIME. SHE IS A REAL MESS. YOU SHOULD SEE BLAH BLAH
THEY THINK I DON'T HEAR
WARD A
OH NO! NOT ANOTHER ONE! THE LAST ONE YOU SENT US IS NOTHING BUT A HEADACHE! SHE BLAH BLAH
NURSING STATION

L. Metzelaar, A Collection of Cartoons.
Ann Arbor, Institute of Gerontology, 1975 (out of print)

FEELINGS, PERCEPTIONS AND REACTIONS

List some of the feelings commonly triggered by the presence of an aging/aged developmentally disabled person.

List the typical perceptions and reactions of other people when they learn that you work with aging/aged developmentally disabled people.

List typical responses that you may make to the individuals who make comments about your work and your clients.

L. Metzelaar, A Collection of Cartoons.
Ann Arbor, Institute of Gerontology, 1975 (out of print)

Classification - Use and Abuse

"I have become a stranger to my brethen
An alien to my mother's son"

Psalms 69:8

I. Definitions*

A. Classification — Systematic arrangement in groups or categories according to established criteria.

B. Label — Anything functioning as a means of identification of a descriptive term, an epithet.

C. Epithet — A term used to characterize the nature of a person or thing. An adjective or descriptive for a person's name or title. An abusive or contemptuous word or phrase used to describe a person.

II. Classification

A. Purpose

B. Examples

C. Range of Purpose

1) Education

2) Social Security

3) Health Agencies

* Definitions from The American Heritage Dictionary of the English Language, New York: American Heritage Publishing Company, 1968.

RANGE OF PURPOSE CHART

CLASSIFICATION	Education	Social Security	Health Agency
Mental Illness			
Down's Syndrome			
Senility			
Learning Disability			

D. Factors Affecting Duration of Need for "Classification"

1.

2.

3.

4.

5.

E. Goals for Service

1.

2.

3.

4.

5.

F. Social/Ethical Issues Affecting Goals Determination

1.

2.

3.

4.

5.

6.

III. Misuse of Classification (Labeling)

A. Causes

1.

2.

3.

B. Result of Labeling (Epithets)

1.

2.

3.

4.

5.

6.

7.

8.

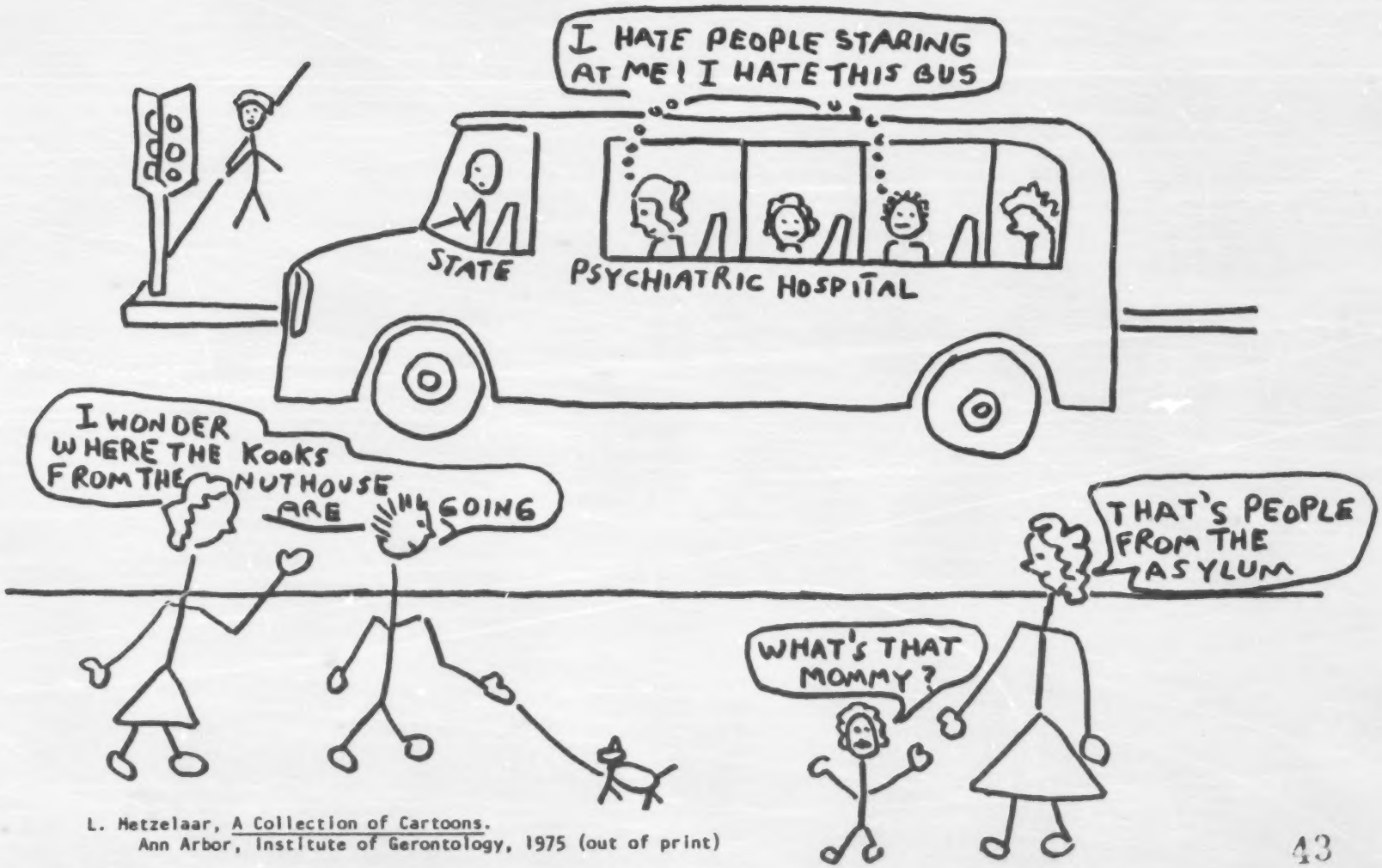
9.

10.

11.

12.

IV. Implications for Practice


I HATE PEOPLE STARING AT ME! I HATE THIS BUS
STATE
PSYCHIATRIC HOSPITAL
I WONDER WHERE THE KOOKS FROM THE NUTHOUSE ARE GOING
THAT'S PEOPLE FROM THE ASYLUM
WHAT'S THAT MOMMY?

L. Hetzelaar, A Collection of Cartoons.
Ann Arbor, Institute of Gerontology, 1975 (out of print)

Situation #1

A group home manager was speaking to a prospective group of new staff members and volunteers who would work with a group of the vulnerable elderly - the aging and aged developmentally disabled. The manager told the group that she understood many of the issues, problems, and concerns of this minority group of elderly people. Speaking to one person she said: "Music is very important to the AADD people. That is why we keep music on in the home all the time when these clients are here. We want the people to feel happy, and music can do that."

Situation #2

Dee, a group home volunteer, had enthusiastically become involved with a program to help an aging and aged developmentally disabled person, Katherine, participate in the activities of Riverside Senior Center. Just after she was assigned her first "friend" Dee's husband took a job in another city. The staff knew it was difficult for Katherine to make friends; she had been rejected many times at the institution where she had lived. Dee would only have 10 weeks to develop and terminate the relationship with Katherine. The senior center staff knew Katherine would benefit from the relationship with Dee, but they wondered how Katherine would be affected when Dee left.

Situation #3

One day, Barb, an older client, was telling Betsy about her family's likes and dislikes, and past experiences in an institution. Betsy found it easy to share some of her personal concerns and hopes for the future with Barb. They talked for an hour, and the conversation was meaningful for both of them. Later Betsy described the incident to the home manager and commented: "I relate to her so well. I wonder what her developmental disabilities are?"

Situation #4

A new staff member, Kathy, was talking to Jack, an older client. Jack expressed his disappointment in the quality of food served at dinner. He felt it should be served better, and he should receive larger portions. The home manager overhearing the conversation, said "Kathy, don't worry about Jack. He always complains about the food. All he wants is attention. Sometimes we don't know what to do with him."

SESSION V

SUPPORT SYSTEMS ARE AGELESS

1. BROKEN SQUARES EXERCISE
   - Small Group: Problem solving and discussion

2. MY SYSTEM OF SUPPORT
   - Large Group: How do you use your relationship to meet your support needs?
   - Solo: What are your personal support system relationships?

3. MY CLIENT'S SUPPORT SYSTEM
   - Small Group: Problem solving around individual support systems
   - Large Group: Share-out

4. IMPLICATIONS FOR INDIVIDUAL PRACTITIONERS

THE BROKEN SQUARES EXERCISE

A community is people helping people. The key to a successful community is communication. By doing the exercise, you will begin to understand what being a community member really involves.

Instructions: Each of you has an envelope containing pieces that will form squares. When you are told to begin, your group is to form five squares of equal size. The task won't be completed until each person has a completed square before him.

Rules:

1. Nobody can talk
2. Nobody can ask anyone else for a piece; others can give you pieces.

Reactions to Game/Feelings Generated

CASE STUDIES

I
Chrystal

Chrystal, 57, is one of the most competent residents in the home, even though her activities are somewhat limited by her use of a walker. Chrystal is in frequent touch with a younger sister's family, and enjoys visiting them. After each of these visits, Chrystal returns to the home, demanding a great deal of attention which leads the staff to believe that her relatives cater to her. When the staff encourages Chrystal to do for herself, she responds by using phrases that they believe she learned on her visits; phrases such as "That's what you're paid for", or "I can't do that."

II
George

George, 47, still lives in the house here he was born. His father died several years ago and his mother is in very poor health. Although George is considered to be "trainable" and has had some job training, he is ill prepared to handle the emergencies that may occur at any time in the situation. He has shared his concerns with the staff at the activities program.

III
Alice

Alice, 52, lived for many years in a state home and training school for the mentally retarded. While there, a worker taught her to use the interurban bus to make weekend visits to her mother. Recently, Alice moved to a group home in a suburb 20 miles from her mother's home. In this situation she finds no support to continue the regular visits to her mother. This development is upsetting to Alice, for her mother's health is failing and she wishes to be with her as much as possible.

IV
Bill

Bill, 49, returned to the community eleven years ago, after 30 years in a state institution. He has made a successful adjustment. Bill has only one living relative, a father who is a retired attorney. Bill's father visits him occasionally in the group home and calls him on the phone. However, he has asked Bill not to come to <u>his</u> home "because my friends don't know about you and they won't understand."

Bill has been an important friend for all of the other residents in the home, giving advice and helping with difficult tasks, i.e. telephoning, banking and shopping. Recently he has become hostile, uncooperative and sullen. When confronted with his behavior, he said "No one helps me."

SESSION VI

COMMUNICATION AND COMMUNITY

1. "WARM UP"

   - Small Group: Sharing strengths and weaknesses
   - Large Group: How attitude affects communication

2. COMMUNICATION WITH THE AADD PERSON

   - Small Group: Why communication?
     What is communication?
     Developing good communication
   - Large Group: Summary
   - Individual: Personal reflection

3. COMMUNICATION ON BEHALF OF THE CLIENT

   - Small Group: Why communication?
     What is communication?
     Developing good communication

4. PRACTICE IN COMMUNICATION

   - Triads: Role playing situations to solve problems

5. TRAINER/TRAINEE DISCUSSION

   - On site problems
   - Training concerns

POSITIVE COMMUNICATION WITH CLIENTS

NOTES: Complete the Strategy Form, A - E, for each of the following situation statements.

1. If you were told by Marge, a client, that two caregivers, you respected very much, were trying to discourage her from purchasing an expensive embroidery kit.....

2. If you were asked by a client, Henry, if it was a good idea to save his money to go on a trip to Toronto.....

3. If you were told by the group home manager to pick up an older client at 2:30 p.m. from the senior citizen center activities. The client informs you that the activities don't end until 3:30. The staff shift ends at 3:00.....

Clarifying Strategy	Situations 1	2	3
A. What would you probably do or say?			
B. What might you have said or done? (list). Be able to discuss how each would/ wouldn't result in favorable long range consequences for the AADD person.			
C. What response would have made you the happiest and proudest?			
D. What comments from other caregivers or clients would support or discourage you from making the "best" decision?			
E. Other comments:			

Developed from: Raths, L., Harmin, M., and Simon, S. Values and Teaching Columbus: Charles E. Merrill, 1966.

COMMUNICATION WITH OTHERS ON BEHALF OF A CLIENT

NOTES: Complete the Strategy Form, A - E, for the following situation statement:

You are a new caregiver who has just joined work the afternoon shift at a group home. You find the other caregiver you work with is not able to control, or gain the respect of an older client who has become very upset because she doesn't want to take her daily bath. The caregiver is trying to physically direct the client toward the bathroom while the client loudly protests. You.....

Clarifying Strategy	Situation
A. What would you probably do or say?	
B. What might you have said or done? (list). Be able to discuss how each would/ wouldn't result in favorable long range consequences for the AADD person	
C. What response would have made you the happeist and proudest?	
D. What comments from other caregivers or clients would support or discourage you from making the "best" decision?	
E. Other comments:	

Developed from: Raths, L., Harmin, M., and Simon, S. Values and Teaching Columbus: Charles E. Merrill, 1966.

I. Communication with the Client

ABIGAIL has been upset about the workshop. For the last two months she's complained of not having enough to do. She says she just hates to sit there and the workshop won't let clients bring along other activities. Abigail loves to embroider and feels the workshop is a waste of her time. Lately, she refuses to get ready for the workshop. Sometimes she says she doesn't feel well. You are her social worker, and the group home manager asked you to talk to Abigail.

1. Try and gain any further information you need.
2. Develop good listening techniques
3. Develop some mutually agreed upon solutions with Abigail.
4. Make sure Abigail is aware of personal and responsibility for her own behavior.
5. Are you modeling assertiveness for Abigail as you interact?
6. Be sure you and Abigail mutually agree on how the home manager will be informed of any decisions.

II. Communication on Behalf of the Client

HARRY is the brother of Ben, a mentally retarded resident of a group home. He has come to talk to you (the group home manager) about some concerns. Ben has called Harry frequently in the last week, and says he is not happy with the home for a number of reasons. He doesn't like the home; he's not happy with the food; residents steal his gloves.

1. Try and gain any further information you need.
2. Develop good listening techniques.
3. Develop some mutually agreed upon solutions with Harry.
4. Attempt to make your solutions involve Ben and personal responsibility for his behavior.
5. Are you modeling assertiveness for the client because he is not a part of this session?

III. Communication on Behalf of the Client

ILENE, a caregiver, has come to you, the home manager, because of a problem with a client. Ellen, the client, refuses to take a bath in the evening. Ilene, who works the early evening shigt, almost hates to come to work because she knows the "battle" that will take place.

1. Try to gain any further information you need.
2. Develop good listening techniques.
3. Develop some mutually agreed upon solution with Ilene.
4. Make sure your solutions involve Ellen, and her personal responsibility for her behavior.
5. Are you modeling assertiveness for this client because she is not a part of this session?

PRACTICE IN COMMUNICATION

Clarifying Strategy

Situation #_____

A. What would you probably do or say?	
B. What might you have said or done? (list). Be able to discuss how each would/wouldn't result in favorable long range consequences for the AADD person.	
C. What response would have made you the happiest and proudest?	
D. What comments from other caregivers or clients would support or discourage you from making the "best" decision?	
E. Other comments:	

Developed from: Raths, L., Harmin, M., and Simon, S. Values and Teaching Columbus: Charles E. Merrill, 1966

SESSION VII

PROBLEMS AND POTENTIALS OF COMMUNITY LIVING

1. "WINDOWS ON THE WORLD"

2. "REDISCOVERING THE COMMUNITY" - Videotape

3. MOVING TO COMMUNITY
   - Part I: Where do I stand?
   - Part II: Risks and Barriers
   - Part III: Challenges and Opportunities

4. COMMUNITY RESOURCES
   - Sharing our expertise

"REDISCOVERING THE COMMUNITY"
Presentation of a videotape

Producer/Director: Jeff Werner
Writer/Narrator: Eunice Thurman

Abstract:

For many elderly retarded individuals, community living has become a long-awaited reality. But living in a community and being part of the community are two different realities. How should clients reach out, and to whom? Caregivers can help in this process, but what problems can be anticipated as clients bridge the gap between themselves and the wider community? This videotape looks at the diversified resources available from the community and suggests ways that clients can return significant contributions to it.

True participants in the human community both give and receive help. Older people with developmental disabilities can be no exception.

After viewing this tape, you should be able to:

1. Discuss why it is important for the client to be integrally involved in the resource-finding process, especially as an individual and not as part of a group.

2. Locate potential resources for the elderly client in your community and describe the difficulty in this process.

3. Identify the major resources available to the person in the areas of:

   a. basic survival needs
   b. interpersonal needs
   c. leisure time
   d. voluntary participation

4. List some of the general community resources available to all community participants, including the elderly, developmentally disabled.

Discussion Questions:

1. In what ways can the family be a valuable resource to the elderly client? How can greater family commitment increase independence?

2. How can older, disabled clients learn the skills necesary to become part of the community? Will these skills seem more valuable if they are practiced in a community setting?

3. Why is the use of older, developmentally disabled people's skills valuable when we talk about "utilizing community resources"?

4. In what ways can clients be resources to each other?

5. Why should older, disabled clients participate in making decisions about their use of community resources?

Suggested Readings:

Holmes, Monica B. and Holmes, Douglas, Handbook of Human Services for Older Persons, New York, NY: Human Services Press, 1979.

Naylor, Harriet. Volunteers Today--Finding Training and Working with Them. New York, NY: Association Press, 1967 (now through Dryden, NY, 1973).

The At-Risk Elderly: Community Service Approaches. Washington DC: National Council on the Aging, 1978. 600 Maryland Ave., S.W. (West Wing) Washington, DC 20024.

Booth, Estelle, M.S.W. Reaching Out to the Hard-to-Reach Older Person, San Francisco, CA: The San Francisco Center, 1973 (800 Beach St., San Francisco, CA 94109, $1.25).

WHAT IT'S LIKE WHERE WE LIVE

INSTITUTION	COMMUNITY
1. Label of diagnosis attached to individuals	1. Freedom of movement in the community, and needs met within the range of community services
2. Maintenance of routines and schedules	2. Personal decision making around organizing one's time
3. Patient/client role is maintained - emphasis is on mental or physical illness	3. Many social roles are available - emphasis is on wellness
4. Effort is made to eliminate stress	4. Stress controlled by individual limitations, strengths
5. Rigid helper roles	5. Flexible helper roles

CELEBRATING/ENJOYING LIFE

	SE LF	AA DD		SE LF	AA DD	
1. telephoning			16. browsing in stores			
2. "hanging out" together			17. walking			
3. visiting zoos, museums			18. smoking			
4. going to amusement parks			19. praying			
5. people-watching			20. camping with friends			
6. window shopping			21. birthday parties			
7. drinking at a tavern			22. traveling with friends			
8. eating out			23. dancing			
9. visiting craft shows			24. visiting your family			
10. parties			25. attending church/synagogue			
11. sightseeing			26. picnicking			
12. staying at resorts			27. bowling			
13. sitting in backyard			28. flirting, dating, making love			
14. driving around for pleasure			29. going to the movies			
15. attending basketball/ football, baseball games			30. attending lectures/ concerts			

LEISURE TIME/SELF IMPROVEMENT

1. cleaning/polishing the car			10. meditation			
2. watching T.V.			11. bird-watching			
3. star-gazing			12. flower arranging			
4. doing jigsaw puzzles			13. letter writing			
5. clam digging			14. gardening			
6. fishing			15. refinishing antiques			
7. canoeing/hunting			16. repairing the house			
8. bicycling			17. candle-making			
9. sledding			18. sewing/quilting			

	SELF	AADD		SELF	AADD	
19. calligraphy			29. doing various crafts			
20. painting/sculpting			30. ice-skating			
21. car repairing			31. skiing			
22. self-development seminars			32. belly dancing			
23. collecting stamps etc.			33. skin diving			
24. photography			34. yoga			
25. exercising			35. parachute jumping			
26. training pets			36. mountain climbing			
27. swimming			37. surfing			
28. jogging			38. horseback riding			

HELPING OTHERS AND OURSELVES

1. volunteer work			6. family activities			
2. school clubs,activities			7. working on political campaign			
3. cooking			8. singing in church choir			
4. community activities			9. giving blood			
5. entertaining			10. voting			

COMPETING WITH OTHERS

1. badminton			6. drama productions			
2. ping-pong			7. crafts competitions			
3. playing cards			8. gambling			
4. tennis/racquetball			9. chess			
5. volleyball			10. bowling			

CONSIDERING COMMUNITY INVOLVEMENT

		RISKS/BARRIERS				
		Small ←				→ Great
1.	telephoning	1	2	3	4	5
1.	"hanging out" together	1	2	3	4	5
3.	visiting zoos, museums	1	2	3	4	5
4.	drinking at a tavern	1	2	3	4	5
5.	eating out	1	2	3	4	5
6.	parties	1	2	3	4	5
7.	staying at resorts	1	2	3	4	5
8.	smoking	1	2	3	4	5
9.	attending ball games	1	2	3	4	5
10.	camping with friends	1	2	3	4	5
11.	dancing	1	2	3	4	5
12.	bowling	1	2	3	4	5
13.	flirting, dating, making love	1	2	3	4	5
14.	fishing	1	2	3	4	5
15.	canoeing/hunting	1	2	3	4	5
16.	bicycling	1	2	3	4	5
17.	flower arranging	1	2	3	4	5
18.	gardening	1	2	3	4	5
19.	letter writing	1	2	3	4	5
20.	painting/sculpting	1	2	3	4	5

Considering Community Involvement (continued)

		RISKS/BARRIERS				
		Small ←				→ Great
21.	car repairing	1	2	3	4	5
22.	photography	1	2	3	4	5
23.	doing various crafts	1	2	3	4	5
24.	training pets	1	2	3	4	5
25.	swimming	1	2	3	4	5
26.	jogging	1	2	3	4	5
27.	ice-skating	1	2	3	4	5
28.	skiing	1	2	3	4	5
29.	horseback riding	1	2	3	4	5
30.	volunteer work	1	2	3	4	5
31.	cooking	1	2	3	4	5
32.	entertaining	1	2	3	4	5
33.	giving blood	1	2	3	4	5
34.	voting	1	2	3	4	5
35.	ping-pong	1	2	3	4	5
36.	drama productions	1	2	3	4	5
37.	craft competitions	1	2	3	4	5
38.	gambling	1	2	3	4	5
39.	attending church/synagogue	1	2	3	4	5
40.	sewing/quilting	1	2	3	4	5

"During the evening, there was a supper-seminar at which the coordinator of the regional mental retardation services gave a brief address. He read a letter which the director of the local sheltered workshop had just received from a mother whose two sons had perished in a fire which destroyed their home. One of the sons, a severely retarded young mongoloid adult, had been a worker in the workshop. The letter, exactly as written, follows.

"Dear Mike and all,

I was in North Platte on a monday but the shop was close.

I wanted to thank all of you for everything you had done for Robert. He was so proud of his job and the ability to do things on his own.

I am very proud of him as he went to the back room to save his brother. He had Donald from the head of the bed to the foot. If he had only a few more minites he would of had Donald out—even tho we know Donald was dead at the time.

I am sending his one check back as they say it would not go thru the machine. put the money in your fund so your books will balance.

to day was my first day back at work. It was a long day but I know I have to keep busy. My two boys was my whole life so now I have to start over. My husband is very under standing—was hurt very bad also.

If I can be of any help at any time please feel free to let me know. I feel I proved to the world a retarded child has a place in the world and can be a useful person.

Many thanks for the picture. All of mine were destroyed. I am very thankful we had some taken the Friday night before the Fire. the Church was taking family portrait's. So I have some of each boy.

Many thanks for everything.

as ever
(signature and town of residence)" [1]

Would Robert have lived longer in a sheltered institutional environment away from the community?

Would Robert have been better off in an institutional placement? Why is risking an important part of living in the community? What do <u>risking</u> and <u>caring</u> have in common?

[1] Wolfensberger, Wolf. <u>Normalization</u>. Toronto: Nat. Institute on Mental Retardation, 1972.

COMMUNITY CHECK LIST

Aging and Aged Developmentally Disabled persons can use the services available for all older Americans. How does your community rate? Does it have....

_____1. A citywide or areawide information and referral center?

_____2. An area agency on aging, local council, or advocate agency?

_____3. Transportation and escort services for the elderly?

_____4. A senior center or centers, offering social activities, recreation, education, and a setting for community services?

_____5. Health care services, including:

a. health clinic
b. health maintenance organizations
c. health screening program

_____6. In-home services, including:

a. visiting nurse service
b. home-health service
c. homemaker service
d. handyman service
e. meals-on wheels
f. friendly visiting
g. telephone reassurance

_____7. Nursing home or homes with high standards and a wide range of fees?

_____8. Group meals program, providing a social setting for improved nutrition for older persons?

_____9. Recreation activities for seniors?

_____10. Libraries, museum, art gallery, and performing arts programs for older people?

_____11. Adult education opportunities?

_____12. Job oportunities?

_____13. Volunteer opportunities?

_____14. Senior talent pool?

_____15. Senior citizens employment service or job registry?

_____16. Legal aid and general counseling?

_____17. Low-rent public housing for the elderly?

_____18. A range of moderate income housing-for sale and rent?

_____19. Repair and renovation program for existing "elderly housing"?

_____20. Property tax relief for older Americans?

_____21. Transportation?

Generally Available SERVICE CONTACTS

1. Department of Social Services
2. Department of Mental Health
3. Department of Health
4. State Office on Aging
5. Area Agencies on Aging
6. Community Mental Health Board
7. Federal Information Centers
8. State Developmentally Disabled Councils
9. University Affiliated Facilities
10. State Protection and Advocacy Offices.
11. ACTION
    - Older Americans Volunteer Programs
      806 Connecticut Ave., NW
      Washington, DC 20525
      (202) 254-7605
    - Foster Grandparent Program
    - Senior Companion Program
    - Retired Senior Volunteer Program
12. Administration on Aging (AOA)
    330 Independence Ave. S.W.
    4760 HHS North Building
    Washington, DC 20201
    (202) 245-0724
13. Administration on Developmental Disabilities
    330 Independence Ave. S.W.
    HHS North Building, Room 3194 C
    Washington, DC 20201
14. Chambers of Commerce
    - Frequently supplies listings of their area clubs and organizations
    - Often there is a directory of services to the aging available
15. UNITED WAY
    - Often a Directory of Human Services (Community Services) is available

16. Legal Aid Societies

17. Libraries for the blind and physically handicapped (call your local library)

18. Phone book. (The headings listed below often supply relevant contacts through the yellow pages):

    a. National groups (also check under Government--U.S., States, or County).

    b. State councils, advocacy, referral groups, and/or service agencies (also check under Government--State).

    c. Group homes

    d. Social Service Organizations

    e. Handicapped Employment

    f. Retirement Communities and Homes

    g. Senior Citizens

    h. Clubs; Public

    i. Homes and Institutions

    j. Rehabilitation Services

    k. Associations

    l. Centers

    m. Schools with Special Academics

    n. Employment Agencies

    o. Chambers of Commerce

    p. Churches

    q. Volunteers (see social services organizations)

    r. Adult Education Programs (see schools--secondary and elementary)

    s. Community Colleges (see schools--universities and colleges)

SESSION VIII

USING THE COMMUNITY

1. "USING THE COMMUNITY"
   - Game/Simulation
   - Large Group: Share-out

2. "BECAUSE SOMEBODY CARES" - Film

SESSION IX

INDIVIDUAL PROBLEM SOLVING

1. PARTICIPANT PREPARATION
   - Small Group: "Preparing" the experts

2. "PANEL OF EXPERTS"
   - Role Play: 1. Discuss immediate problems and concerns
     2. Allow participants to evaluate the experts' "performance"

3. TRAINEE PROBLEM SOLVING
   - Triad: Individual problem solving
   - Large Group: Comments on problem solving approaches

SESSION X

A LIFETIME OF AGING

1. "A LIFETIME OF AGING"

   PART I

   - Solo: Identify growth and change processes of various life phases
   - Dyad: Discuss ideas/experiences with another participant
   - Small Group: Share-out how the aging process is alike/different for the AADD person

   PART II

   - Dyad: Identify and discuss ideas and experiences with the characteristics of the life phases: loss, rejection, withdrawal, alienation, separation, and termination
   - Small Group: Share-out how these characteristics are alike/different for the AADD person
   - Large Group: Implications for individual practitioners

2. "ROSE BY ANY OTHER NAME" - Film

3. EVALUATION
   - Large Group: Emphasizing strengths/weaknesses of the training process

SIDE I

"A LIFETIME OF AGING"

The aging process starts at birth and involves physical, social, emotional, and psychological changes for the duration. What are some of these changes, and what should a person learn about his own aging process during the various phases?

BIRTH

PRE-ADOLESCENCE(0-10)

ADOLESCENCE(10-20)

YOUNG ADULTHOOD(20-40)

MIDDLE AGE(40-60)

OLDER ADULTHOOD(60-)

DEATH

SIDE II

"A LIFETIME OF AGING"

The purpose of this exercise is to become aware of how certain conditions pertaining to relationships (loss, rejection, withdrawal, alienation, separation, and termination) affect persons at different life phases.

BIRTH

PRE-ADOLESCENCE(0-10)

ADOLESCENCE(10-20)

YOUND ADULTHOOD(20-40)

MIDDLE AGE(40-60)

OLDER ADULTHOOD(60-)

DEATH

EVALUATION

1. What was your best experience during these ten sessions of training? Why?

2. What experiences proved to be the least helpful to you? Why?

3. List five learnings that you gained during the training. Number them in their order of importance to you. (prioritize -1, 2, 3,.)

4. List five learnings that were unimportant to you during the training. Why?

5. Please place a number by the item that best explains its usefulness to you, during the training.

		Useless				Very Useful
a.	films, videotapes etc. comments:	1	2	3	4	5
b.	large groups, small groups, dyads, triads comments:	1	2	3	4	5
c.	lecturettes comments:	1	2	3	4	5
d.	vignettes for problem solving role play etc. comments:	1	2	3	4	5
e.	games - example: community resources game comments:	1	2	3	4	5